DOCUMENT RESUME

ED 094 281 CG 009 014

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TITLE Emotional Adjustment in Terminal Patients.
PUB DATE May 74
NOTE 8p.; Paper presented at the Midwest Psychological Association Meeting (Chicago, Illinois, May 1974)

EDRS PRICE MF-$0.75 HC-$1.50 PLUS POSTAGE
DESCRIPTORS Adjustment (to Environment); *Adults; *Clergymen; *Counseling Programs; *Death; *Emotional Adjustment; Hospitals; Interpersonal Relationship; Research Projects; Speeches

ABSTRACT

A quantitative apporach was used to identify factors relating to emotional adjustment in 84 dying patients. Eleven hospital chaplains collected data by interviewing dying patients. Results indicate that emotional adjustment to the awareness of a limited life expectancy was not related principally to religious orientation, although this was an important factor. Emotional adjustment was influenced more by the patient's physical condition (level of discomfort), by previous experiences with dying persons, and by interpersonal relationships. The most important aspect of the religious variable was the quality of religious orientation rather than mere religious affiliation or verbal acceptance of religious beliefs. (Author)

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EMOTIONAL ADJUSTMENT IN TERMINAL PATIENTS

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An address to the Midwest Psychological Association
Chicago, Illinois - May 2, 1974

by
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To learn one is incurably ill is a crisis for the average person. Some people cope adequately with the psychic pain that may come in the form of anger, depression, fear, or inappropriate guilt. They adjust emotionally to the point they can live the final weeks and months of their lives with inner tranquility. Other patients are unable to handle this pain.

Most investigators have used a qualitative or case study approach to examine emotional adjustment to a limited life expectancy. Dr. Kubler-Ross's (1969) investigations exemplify this approach. Only one previous investigator used a quantitative approach. Farkas (1973) used psychologial tests and interviews to study the psychological adaptation of families of children with cystic fibrosis. The present research project used a quantitative approach to identify factors that correlate with emotional adjustment in terminal patients.

Many factors might influence the degree of adjustment to the awareness of terminal illness. First, one might expect the amount of pain and discomfort to be an important factor. The greater a patient's pain and incapacity, the more his previous life-style, work, and entertainment will be disrupted.

The amount of social support one receives from significant others in one's life might be an important element in emotional adjustment. The quality of the relationship with one's nearest of kin, especially one's spouse, should be a large factor because of the permanence and intimacy of this relationship. One's close friends can be a factor, especially where family ties are weak or non-existent. The concern of one's physician might be important, especially for a patient who has had a long and deep relationship with him. The relationships

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with local clergymen, hospital chaplains, and nurses should be of less importance because these are usually more superficial and transitory.

Previous experience with death situations might be a factor. Bandura and Walters (1963) found the concept of vicarious learning useful in analyzing modeling or imitative behavior. A patient who previously had been close to a dying person might be said to have gone through the same experience vicariously. If the person the patient knew had handled this experience with inner peace, he may have learned how to handle his own crisis with inner peace. If his previous experience was with a person who handled the crisis badly, the patient might then have poorer emotional adjustment.

The effect of religion on emotional adjustment might depend not only on the content of the beliefs but on how well one has lived according to these beliefs. French and Raven (1959) listed reward power among several different bases of social power which might influence opinions and actions. A terminally ill person who truly believes in an afterlife and in a personal God who could either reward or withhold reward from him according to his past behavior might behave differently in the face of death than a non-believer. A believer who had lived in accordance with his beliefs should have greater emotional adjustment than a non-believer because of his confidence and trust in meeting a God who will reward him. A believer who had lived at variance with his beliefs should have poorer emotional adjustment than a non-believer because of his concern about the possibility of punishment after death.

Financial security should have a positive effect on emotional adjustment because it would remove much concern about how one's loved ones would be cared for after a person's death.

Method

Subjects

This research project was incorporated into a program of patient service. Every patient at Lutheran General Hospital in Park Ridge, Illinois, receives a visit from a chaplain who offers a varied ministry to both patient and family in the form of counseling, prayer, or the sacraments. This project required that in addition to standard pastoral care the chaplain offer his service as counselor specifically to deal with the patient's feeling regarding his serious illness, continue the established relationship in the event the patient left the hospital, and offer the patient the opportunity to help others by sharing his feelings by means of an orally-administered questionnaire.

In this project a terminally ill person was defined as one whose illness was such that death was probable within a year if the unwholesome condition persisted, and no cure was known for the patient's condition. Only patients who were aware of the seriousness of their condition were candidates for the project. Patients who were unaware of the potential fatality of the illness, who were *in extremis*, or who were too weak or sedated for counseling were not considered as candidates for the project. Referrals were made by nurses, student chaplains, and physicians.

The offer of counseling was made to 84 candidates between December 15, 1972 and July 31, 1973. Half were male and half were female. They ranged in age from 13 to 82. Two-thirds were married, 17 percent were widowed, 11 percent were single, and 5 percent were divorced. Ninety-two percent were cancer cases. Forty-eight percent were Protestant, 37 percent were Catholic, 6 percent were Jewish, and 8 percent had no religious affiliation. Seventy-four patients, 88 percent, accepted the offer of counseling.

Measures and Statistical Analysis

The main dependent variable in this study was the Emotional Adjustment (EA) scale. The scale was designed to measure the extent to which a terminal patient was able to cope interiorly and exteriorly with his limited life expectancy.

The EA scale consisted of six questions which the chaplain rated on the basis of the patient's words and behavior, as well as on information obtained from the staff and the patient's family. The questions measured the presence or absence of anger, guilt, anxiety, depression, and also the ablilty of the patient to verbalize his feelings with family and friends.

The discomfort scale was formed from five items. The chaplains evaluated the patient's amount of pain, disfigurement, dependence on others, difficulty in eating, and difficulty in sleeping.

The relationship between religion and emotional adjustment was examined using religious affiliation, religious beliefs, and the quality of religious orientation as criteria. Four categories of religious orientation (RO) were considered: intrinsic, extrinsic, indiscriminately proreligious, and indiscriminately nonreligious. Gordon Allport characterized an intrinsically religious person as one who takes seriously the commandment of brotherhood, strives to transcend self-centered needs, tempers his dogma with humility, and seems to live the teachings of his faith. The extrinsically orientated person is characterized by Allport as the one who takes a self-centered approach to life, looking after his own personal safety, social standing, and chosen way of life. This person seeks to use religion rather than to live it. His is a utilitarian orientation to religion.

In this study a revised form of the original Allport scale was used to measure religious orientation. The RO measure was scored by summing each patient's total for both the intrinsic and extrinsic subscales. Patients were classified as intrinsic or extrinsic if they scored above the median on one of these scales, but not on the other. They were indiscriminately pro-religious if above the median on both scales, indiscriminately nonreligious if below the median on both scales.

Previous experience with dying persons was analyzed from three standpoints: 1. Whether the patient had ever talked frankly and openly about death with someone else who knew he was dying; 2. whether he was close to someone who accepted death with inner peace; and 3. whether he had been close to someone who was angry or upset until the end of his life.

Ratings of occupational status obtained from the National Opinion Research Center were used as an indirect measure of financial security.

The EA scale, the discomfort scale, and the scales of intrinsic and extrinsic religious orientation were factor-analyzed. The results of factor analysis and item-scale correlations showed that the scales were cohesive and adequate for evaluating hypotheses.

EA scores were divided into two groups on the basis of the median score, so that an equal number of respondents were considered to have high and low emotional adjustment. Hypotheses were tested by crosstabulating the categories of each independent variable with emotional adjustment and then reporting the percentage of patients who had high EA. The gamma statistic was used to indicate strength of predictive association. Finally, multiple regression analysis was used to examine the combined power of the more important variables in predicting emotional adjustment.

Summary of Principal Findings

What were the main factors that predicted emotional adjustment to a limited life expectancy? The most important factors were the level of discomfort; previous close contact with a person who was dying; religious orientation; amount of interest of kin and local clergyman; and amount of education.

Level of discomfort was negatively related to emotional adjustment. Having been close to a person who accepted death with inner peace was a positive factor in emotional adjustment, while having been close to a dying person who was angry and upset was a negative factor. Female patients who had prevously discussed death openly and frankly with another dying person had a much greater ability to cope. The quality of religious orientation rather then mere religious affiliation or verbal acceptance or religious beliefs, was the most important religious variable. Intrinsically religious persons (those who tried to integrate their beliefs into their life styles) had the greatest emotional adjustment. However, Christians had much higher emotional adjustment than non-Christians. Education was positively related to emotional adjustment, possibly because both are related to financial security.

Discussion

The results suggest that one of the most important things a person can do to prepare himself for the possibility of terminal illness is to welcome the opportunity to be close to someone who is presently facing terminal illness with inner peace. Talking frankly about death and dying may not only help the patient sort out his own feelings, but also assist the other person to adjust emotionally if he in turn contracts an incurable illness. If one is the main breadwinner of a family, it seems advisable to plan financially ahead of time, so that dependents will have security in the event of a sudden illness. Removing financial worries eliminates one road block to emotional adjustment. For relig-

ious persons, integrating religious beliefs onto one's life style may reduce the possibility of guilt and concern about God's anger, increase trust in God's loving care, and sustain a well-founded hope in a life of happiness after death, in the event of terminal illness. Finally, cultivating deep and loving relationships with family and friends will provide a solid support in the face of death.

Counselors must be willing to share the helping with others. Terminal patients have many needs. No one person can possibly fulfill all these needs. Physicians, family, clergy, nurses, friends can all make a contribution. Second, a patient must sense that his own way and style of dealing with dying are acceptable to the counselor. While the counselor is available to help the patient look for alternatives, he must primarily help the patient capitalize on his own resources. Finally, counselors will avoid some frustration if they recognize that some factors are beyond their control. They cannot remove the patient's physical pain, supply past experiences, provide financial security, or quickly change past relationships with family and friends.

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